## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/23/2013 FORM APPROVED OMB NO. 0938-0391

STALEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	TE SURVEY MPLETED	
		445278	B. WING	_		10	14/2013
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKE	EWOOD NURSING CE	ENTER, INC			332 RIVER ROAD		
					DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 021 SS=D		FETY CODE STANDARD	K 0	21	K 021		
	enclosure, horizont	passageway, stairway al exit, smoke barrier or			NFPA 101 LIFE SAFETY CODE STAN	DARD	
		closure is held open only by			The fire door was repaired on Octo	ber 16,	
		o automatically close all such roughout the facility upon			2013.		
	activation of:				All fire doors were checked by the		
	a) the required man	ual fire alarm system;			Maintenance Director on October	16, 2013	
		•			to ensure the fire doors had a posi	tive latch	
	b) local smoke detectors designed to detect smoke passing through the opening or a require				Maintenance Director will monitor	the fire	
	smoke detection sy				doors to ensure that the doors hav	-	
	c) the automatic co	rinkler system, if installed.			positive latch weekly for three mor		
	19.2.2.2.6, 7.2.1.8.	2			Administrator will monitor the fire		
					a positive latch monthly for three r	nonths.	
ļ					The Maintenance Director will repo	ort result	
					of the audit to the Quality Assuran		
					Committee(Administrator, Director	of	
		not met as evidenced by:			Nursing, Assistant Director of Nursi		
		on and interview, it was ity failed to ensure corridor			Medical Director, Business Office N	• .	
	fire doors closed to	a positive latch. (NFPA 101,			Dietary Manager, Social Service Dir	-	
İ	19-3.6.3.)	,			Medical Records, Housekeeping an		
	The findings include				Laundry Supervisor, Therapy Mana	ger, MDS	
	The indings include	•			Coordinator Activities Director and		
į	Observation and inte	erview with the Maintenance			Pharmacy Consultant), monthly for		
		14, 2013 at 2:25 p.m.			months for further review or correct	tive	
	confirmed the corrid failed to close to a p	or fire door by room 204			action if indicated.		
		ified by the Maintenance					
	Supervisor and ackr	nowledged by the					
		the exit conference on					
	October 14, 2013.	ETY CADE STANDARD	1/ 05	٦0			
		ER/SUPPLIER REPRESENTATIVE'S SIGN	K 02	_ <del></del>	// TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

		A MICOLONIO OF WATCH				UNIO INC	<u>, 0936-039</u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION 01 - MAIN BUILDING 01	FE SURVEY MPLETED			
		445278	B. WING	;		10	/14/2013		
NAME OF PROVIDER OR SUPPLIER  BROOKEWOOD NURSING CENTER, INC				STREET ADDRESS, CITY, STATE, ZIP CODE  332 RIVER ROAD  DECATUR, TN 37322					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
K 029 SS=E	Continued From pa	ge 1	к	)29	К 029				
00 2	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire				NFPA 101 LIFE SAFETY CODE STAND	DARD			
	extinguishing syster	n in accordance with 8.4.1			The damaged sheetrock in the drye	room			
ĺ	the approved autom	ects hazardous areas. When atic fire extinguishing system	<b>!</b> :		was repaired on October 29, 2013.				
	option is used, the areas are separated from other spaces by smoke resisting partitions and				The damaged sheetrock in the ceilin	g of the			
	doors. Doors are se	elf-closing and non-rated or		ļ	sprinkler riser room was repaired or	1	İ		
1	field-applied protective plates that do not exceed				October 29, 2013. The fire stop was	applied	t		
	48 inches from the beginning permitted. 19.3.2.	oottom of the door are		į	on October 30, 2013.				
					The 4 X 8 piece of sheetrock in the k	itchen			
					ceiling was repaired on October 22,	2013.			
	This STANDARD is	not met as evidenced by:		ľ	The attic headwall joint will be repa				
ł	Based on observation	on and interview, the facility			November 15, 2013, along with the	firewall			
	failed to ensure the I construction is main			İ	rating verified ensure proper				
f	The findings include	:		ļ	documentation for the wall.				
ļ	Observation and inte	erview with the Maintenance 14, 2013 between 10:15 am			The Maintenance Director will moni	tor and			
İ	and 2:45 p.m. confin	med the following:			repair any damage sheetrock in the	facility			
1	<ol> <li>Damaged sheetro</li> </ol>	ck in ceiling of dryer room			and report the finding the Quality				
	around dryer duct.  2. Damaged sheetro	ck in ceiling of sprinkler riser		ļ	Assurance Committee(Administrato				
ļ	room and non-appro	ved fire stop material used			Director of Nursing, Assistant Director Nursing, Medical Director, Business				
	(sheetrock mud) for p				Manager, Dietary Manager, Social Se				
	3. Damaged 4' X 8" p ceiling.	piece of sheetrock in kitchen		İ	Director, Medical Records, Houseker				
	<ol><li>The attic headwall</li></ol>	joint, by access opening by			and Laundry Supervisor, Therapy Ma	, -			
ļı	rooms 104 and 202,	was not sealed. The wall			MDS Coordinator Activities Director				
	was labeled as 1-not rocked on one side b	r firewall and was only sheet			Pharmacy Consultant), monthly for 3	3			
ļ <b>-</b>	These findings were	verified by the Maintenance			months for further review or correct				
	Supervisor and ackno	owledged by the he exit conference on		]	action if indicated.				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		A MEDICAID SERVICES			O	MB NO.	. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445278		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  (X3) D			
		B. WING	§		10/14/2013		
NAME OF PROVIDER OR SUPPLIER				,	STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOK	EWOOD NURSING CE	INTER INC		] ;	332 RIVER ROAD		
BITOOIT	CIVOOD NORSING CE	INTER, INC		1	DECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETIC DATE
K 045 SS=E		FETY CODE STANDARD	K	045	K 045		
	Illumination of mea discharge, is arrang lighting fixture (bulb	ns of egress, including exit ged so that failure of any single ) will not leave the area in es not refer to emergency			NFPA 101 LIFE SAFETY CODE STAND The outside lights at the exits from	the front	
	lighting in accordan	ce with section 7.8.) 19.2.8			sidewalk, sunroom exit, rear physica	al	
		19.2.0	<u> </u>		therapy exit sidewalk to the parking	lot area	
					will have lights connected to the em	ergency	
	<u> </u>				power for egress. This must be com	plete by	
	This STANDARD :	net met ee evidee de u			an outside vendor and the completi	on date	
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure outside egress paths were				will be November 26, 2013.		
	provided with egres The findings include	s lighting to the public way.			The Maintenance Director will repo- completion to the Quality Assurance	2	
	Director, on Octobe confirmed the outside	erview with the Maintenance r 14, 2013 at 10:45 a.m. de lights at the exits from the			Committee (Administrator, Director Nursing, Assistant Director of Nursin	ıg,	
	front sidewalk, sunn therapy exit sidewal	oom exit, rear physical k to the parking lot area were ress lighting (must be on			<ul> <li>Medical Director, Business Office M</li> <li>Dietary Manager, Social Service Dire</li> <li>Medical Records, Housekeeping and</li> </ul>	ctor,	
	emergency power). This finding was ver	ified by the Maintenance			Laundry Supervisor, Therapy Manag Coordinator Activities Director and	- 1	
	Supervisor and acknowledged by the administrator during the exit conference on October 14, 2013.			Pharmacy Consultant), review or col action if indicated.	rrective		
K 052 SS=D		ETY CODE STANDARD	К0	52	action in indicated.		
	installed, tested, and with NFPA 70 Nation	required for life safety is I maintained in accordance al Electrical Code and NFPA an approved maintenance					
	and testing program requirements of NFF	complying with applicable					
						ļ	
				- 1		i	

			<del></del>			ID NO.	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION ( 01 - MAIN BUILDING 01	E SURVEY IPLETED	
. <u></u>		445278	B. WING	÷		10/	14/2013
NAME OF PROVIDER OR SUPPLIER BROOKEWOOD NURSING CENTER, INC				3.	TREET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD ECATUR, TN 37322		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 052	Continued From pa	ge 3	K	052	K052		
K 067 SS=F	Based on observati provide a smoke de fire alarm control un that are not continued 1-5.6.) or a strobe in bathroom.  The findings include 1. Observation and Maintenance Directed 2:45 p.m., confirmed Panel (FACP) was let that was not provide 2. 1. Observation and Maintenance Directed 2:35 p.m., confirmed bathroom was not provide 2. 1. Observation and Maintenance Directed 2:35 p.m., confirmed bathroom was not provide 2:35 p.m., confirmed bathroom was not provided 2:35 p.m., confirmed bathroom was not provided 3. New Maintenance Directed 2:35 p.m., confirmed bathroom was not provided 3. New Maintenance Directed 3.	interview with the or, on October 14, 2013 at d the main Fire Alarm Control ocated in the sprinkler room of with a smoke detector, and interview with the or, on October 14, 2013 at d the handicap accessible rovided with a visual e (strobe).  verified by the Maintenance nowledged by the the exit conference on ETY CODE STANDARD and air conditioning comply f section 9.2 and are installed	КО	67	The smoke detector will be installed to outside vendor. The completion date November 25, 2013.  The visual notification appliance (strollight) will be installed in the handicap accessible bathroom. The completion is November 25, 2013.  The Maintenance Director will report completion to the Quality Assurance Committee (Administrator, Director on Nursing, Assistant Director of Nursing, Medical Director, Business Office Man Dietary Manager, Social Service Direct Medical Records, Housekeeping and Laundry Supervisor, Therapy Manager Coordinator Activities Director and Pharmacy Consultant), review or correction if indicated.	by an test is the the for, mager, tor,	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED	
445278			B. WING			10/	14/2013	
NAME OF PROVIDER OR SUPPLIER  BROOKEWOOD NURSING CENTER, INC				33	FREET ADDRESS, CITY, STATE, ZIP CODE 32 RIVER ROAD ECATUR, TN 37322			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPULATION OF THE PROPULATION OF THE PR	PRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE		
K 067	Continued From pa	ge 4	K o	67	K 067			
	This STANDARD is not met as evidenced by: NFPA 90A, 3-4.7 Maintenance - At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.  Based on observation and interview, interview and record review, it was determined the facility failed to ensure fire dampers were maintained in accordance with NFPA 90A.  The findings include: Record review and interview with the maintenance director on October 14, 2013 at 1:30 p.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers.  This finding was verified by the Maintenance Supervisor and acknowledged by the administrator during the exit conference on October 14, 2013.				NFPA 101 LIFE SAFETY CODE STAND The four year required maintenance fire dampers will be completed by November 29, 2013  The Maintenance Director will report completion to the Quality Assurance Committee (Administrator, Director Nursing, Assistant Director of Nursin Medical Director, Business Office M Dietary Manager, Social Service Director Medical Records, Housekeeping and Laundry Supervisor, Therapy Manage Coordinator Activities Director and Pharmacy Consultant), review or co	e to the  rt the e of anager, ector, d ger, MDS		
	Cooking facilities are with 9.2.3. 19.3.2.  This STANDARD is NFPA 96, 8-2* An infire-extinguishing system shall be months by properly the Based on observation.		K 04	69	K 069  NFPA 101 LIFE SAFETY CODE STAND  Upon review by the Maintenance Di and confirm by the outside contract inspection of the kitchen hood supp system was done in a timely matter, inspection was completed on May 1 The next inspection will be conducted November 15, 2013.	rector or the ression . The 4, 2013		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED	
445278			B, WING	<del></del>	10/14/2013		
	PROVIDER OR SUPPLIER	NTER, INC	3	STREET ADDRESS, CITY, STATE, ZIP CODE 332 RIVER ROAD DECATUR, TN 37322	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HOULD BE COMPLE		
K 144 SS=F	Maintenance Direct 9:45 a.m. confirmed system was last ins This finding was ver Supervisor and ack administrator during October 14, 2013. NFPA 101 LIFE SAI	or, on October 14, 2013 at the kitchen hood supression pected on 11-13-2012. Fified by the Maintenance nowledged by the gathe exit conference on FETY CODE STANDARD rected weekly and exercised inutes per month in	K 069	ensure that semi- annual inspection conducted in a timely matter.  The Maintenance Director will report completion to the Quality Assurance Committee (Administrator, Director	t the of anager, ctor, er, MDS		
	Based on record redetermined the facility emergency generated bank test. The findings include Record review of the with the Maintenance 2013 at 10:00 a.m. regenerator was run upless than 30% of nare emergency Generated on 9-16-2008 and was annual basis. Interview Director revealed he requirement.	not met as evidenced by: view and interview, it was ty failed to ensure the or had an annual 2-hour load  Emergency Generator logs a Director, on October 14, evealed the emergency nder load monthly with a load meplate rating. The lkast or 2-hour load bank test was as not performed on an ew with the Maintenance was not aware of this annual		NFPA 101 LIFE SAFETY CODE STAND The Generator 2-hour load bank test conducted by November 22, 2013. The Generator 2-hour load bank test conducted on a annual basis to meet required standard. The Maintenance Director will monitensure the annual load test is done to the Maintenance Director will report completion to the Quality Assurance Committee (Administrator, Director Nursing, Assistant Director of Nursing)	t will be t will be t the tor to timely.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
B. WING	10/14/2013		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  332 RIVER ROAD  DECATUR, TN 37322	1011-122010		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPRIES OF THE PROPRIES OF T	D BE COMPLÉTION		
K 144 Continued From page 6 Supervisor and acknowledged by the administrator during the exit conference on October 14, 2013.  K 144  K 144  Medical Director, Business Office M Dietary Manager, Social Service Dir Medical Records, Housekeeping an Laundry Supervisor, Therapy Mana, Coordinator Activities Director and Pharmacy Consultant), review or coaction if indicated.	ector, d ger, MDS		